MEDICARE-APPROVED DISCOUNT DRUG MODEL DOCUMENT
Denial Letter –Drug Card & Transitional Assistance

[Date]

<Beneficiary's Name>
<Address>
<City>, <State> <Zip Code>

Dear [insert name (HIC#)]:

You recently applied for our Medicare approved discount drug card and a credit of up to $600 to help pay for your prescription drugs. This letter is to inform you that **you are not eligible for the $600 credit**. However, you may still be eligible to enroll our discount drug card [*Note to sponsor - include this language if card has enrollment fee:* "for an annual fee."].

If you are interested in enrolling in our discount drug card, please call our Customer Service Department [insert hours of information] at l-xxx-xxxx (TTY users should call 1-xxx-xxx-xxxx) for more information. [*Note to sponsor – do not include attachment at end of this letter*.]

[*Alternative language for sponsors who do not have a phone enrollment process – include attachment at end of this letter:* **"**If you are interested in enrolling in our discount drug card, please sign, date and mail the enclosed form to the address provided."]

Our records and/or information that you provided indicate you are not eligible for the $600 credit because:

1. _____ You reside outside of [insert company name's] service area. [Option to sponsor – you may list service area by zip codes and/or counties].

2. _____ You do not have Medicare.

3. _____ You are receiving outpatient prescription drug assistance from Medicaid, also known as [insert state-specific program name]. Since you are receiving such assistance, you are not eligible for the discount card program or the $600 credit. If you have questions, call **1-800-MEDICARE (1-800-633-4227)**. (TTY users should call 1-877-486-2048) for more information on your State Medicaid program.)

4. _____ You are enrolled, or your enrollment is pending, in another Medicare approved discount drug card.

5. _____ You are enrolled in a health plan that offers a Medicare approved discount drug card only to its members. If you want to enroll in a drug card, you must enroll in the drug card offered by your plan.

6. _____ You have indicated that you have TRICARE (military health insurance).

7. _____ You have indicated that you have FEHBP (health insurance for Federal employees or retirees).

8. _____ You have indicated that you have health coverage other than Medicare that includes prescription drugs (such as employer, retiree plans, or an individually-purchased policy). (**Note**: If your other health coverage is through a Medigap plan, or a Medicare+Choice plan, you should contact us at [insert company 1-800#]).

9. _____ Your income, based on your family size, is above the amount allowed. The maximum amount allowed for a single person in 2004 is $ 12,569 and $16,862 for a married couple [*NOTE TO SPONSOR: If for Alaska or Hawaii, FPL figures are different. Please insert correct amounts provided in model instructions.*]

10. _____ You attempted to enroll outside of the annual enrollment period.

11. _____ You reside in a U.S. territory.

How can I have my denial reviewed?

If you believe that any item(s) we have checked is wrong, or if any information you gave us has changed, you have the right to have this decision reviewed. In addition, you may also reapply for this additional assistance if your situation changes in the future.

If you would like to have this denial reviewed, you must submit a request within 60 days from the date on this letter - either by phone, mail, or fax - to the Medicare Drug Card Reconsideration Contractor:

1. **TELEPHONE:** Call the Medicare Drug Card Reconsideration Contractor at 1-800-567-0757. Please have this letter with you when you call.
2. **MAIL:** Mail a copy of this letter to the Medicare Drug Card Reconsideration Contractor, **BOWLING GREEN STATION, P.O. BOX 5042, NEW YORK, NY 10274-5042**. Please fill in your address (if different from above) and phone number in the space provided below. Keep a copy of this letter for your records.
3. **FAX:** Fax a copy of this letter to the Medicare Drug Card Reconsideration Contractor at 917-228-8600. Please fill in your address (if different from above) and phone number in the space provided below. Keep a copy of this letter for your records

Your Address (if different from above): _____

_____

Your phone number: _____

____ If mailing or faxing request, please check this box to indicate you are requesting reconsideration of your denial.

In order to make this review as quick as possible, it may be helpful to provide any evidence or other documentation that may prove that you were incorrectly denied. For example, if you were denied because of Reason #2 (You do not have Medicare), you may send the Medicare Drug

Card Reconsideration Contractor a copy of your Medicare card or other evidence that shows you have Medicare.

Please note that even if you provide additional information, you may still be contacted if more information is needed.

Where can I get more information?

- Please call our Customer Service Department [insert hours of information} at l-xxxxxxx if you have any questions. (TTY users should call1-xxx-xxx-xxxx).

- If you have general questions about the Medicare approved discount drug card, you should call **1-800-MEDICARE (1-800-633-4227)**. (TTY users should call 1-877486-2048).

- If you have questions about having your denial reviewed or information you should submit with your request contact Medicare Drug Card Reconsideration Contractor at 1-800-567-0757.

Sincerely,

Model attachment: **For use by sponsors who do not have a phone enrollment process**

<Beneficiary's Name>
<Address>
<City>, <State> <Zip Code>

Dear [insert name (HIC#)]:

I recently applied to your approved discount drug card and a credit of up to $600 credit to help pay for my prescription drugs and understand that I am not eligible for the credit of up to $600.

I still would like to apply for the [insert company name's] discount drug card and understand that I am responsible to pay the annual enrollment fee in the amount of [insert $$$ amount].

I understand that my enrollment is subject final review by Medicare and you will send me a letter confirming my enrollment in [insert company] discount drug card.

Signature: _____ Date: _____

Please mail this form to:

<insert mailing address.